Public Employees Benefits Board (PEBB)

Uniform Medical Conversion Plan Enrollment Form

This enrollment form is for Uniform Medical Plan conversion only. All other PEBB plan enrollees should apply for conversion directly with the plan they are currently enrolled in.

Type or print clearly in black ink. Inaccurate, incomplete, or illegible information will delay your coverage.

SECTION 1: Subscriber Information

Uniform Medical Plan I.D. Number	Last Name	First Name	Middle Initial

House Number	Street Address	Apt./Unit Number	Date of Birth	☐ Female ☐ Male

City	State	ZIP Code +4	County (Residence)	Phone Numbers Work Home

SECTION 2: Dependent Information (List family members you wish to cover)

Last Name	First Name	Middle Initial	Date of Birth	Relationship	Social Security Number

COBRA End Date	Conversion Plan Effective Date

SECTION 3: Conversion Plan Selection (Check one box)

Plan I ($500 deductible) ☐	**Comments**
Plan II ($1,000 deductible) ☐	

SECTION 4: Signature

Your application and premium payment must be postmarked within 31 days after the termination date of your group coverage. When you apply on time and pay the first month's premium, your coverage will be effective on the date your PEBB group medical coverage terminated. Your check or money order should be made payable to the State Treasurer.

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Signature Please sign printed copy _____ Date _____

Washington State Health Care Authority
Public Employees Benefits Board

Return completed form and payment to:

Health Care Authority
P.O. Box 42695
Olympia, WA 98504-2695

HCA 54-420 (10/05)